Basic Health™

FAMILY CHANGES FORM

NOTE: *Your social security number is voluntary, except where noted.*

SECTION ONE

APPLICANT

Social security number (SSN) – –	Last name	First name	Middle initial

House number Street address Apt./Unit number	City	County	State	ZIP Code
Mailing address (if different from street address)	City	County	State	ZIP Code

Home phone number ( )	Daytime phone number ( )	Are you a U.S. citizen or lawfully admitted for permanent residence? ❑ Yes ❑ No If yes, list date of arrival / /	Birth date / /	Sex ❑ Male ❑ Female

Applying for coverage for yourself? ❑ Yes ❑ No	Are you: ❑ Single ❑ Legally married ❑ Separated ❑ Divorced If married, separated, or divorced, give effective date: / /	Do you want coverage for someone who is currently pregnant? ❑ Yes ❑ No If yes, include their social security number (SSN) and doctor's verification of pregnancy. List the full name and due date of the person who is pregnant: Name Due date / / Doctor's phone number ( )	Do you need an interpreter? ❑ Yes ❑ No If so, we will talk with you through an interpreter. What language do you speak?

Are you disabled and over age 19? ❑ Yes ❑ No If yes, are you receiving Social Security Disability? ❑ Yes ❑ No Entitlement date / /	Eligible for Medicare? ❑ Yes ❑ No	Are you receiving medical assistance from DSHS? ❑ Yes ❑ No	Are you applying for coverage for a child with an urgent medical need? ❑ Yes ❑ No If yes, include their SSN. Name	Are you applying for: ❑ Individual coverage ❑ Group coverage (employer, financial sponsor, or home care agency)

Are you applying for Basic Health *Plus* or the Maternity Benefits Program for anyone on this form, and want to be referred to DSHS for help with unpaid medical bills from the last three months? ❑ Yes ❑ No **If yes**, attach proof of income for those three months and provide the social security number for this person.

SPOUSE If you are legally married, list your spouse even if (s)he is not applying for coverage. If your spouse does not live in your household, or if you and your partner are living in the same household but are not married, your spouse or partner needs to fill out a separate application to apply for coverage.

Last name	First name	Middle initial	Social security number – –	Birth date / /	Sex ❑ Male ❑ Female

Applying for coverage for your spouse? ❑ Yes ❑ No	U.S. citizen or lawfully admitted for permanent residence? ❑ Yes ❑ No If yes, list date of arrival / /	Disabled and over age 19? ❑ Yes ❑ No If yes, receiving Social Security Disability? ❑ Yes ❑ No Entitlement date / /	Eligible for Medicare? ❑ Yes ❑ No	Receiving medical assistance from DSHS? ❑ Yes ❑ No

DEPENDENTS If you are applying for Basic Health *Plus* coverage for your child, you must provide the child's social security number. If you have more than two dependents, please provide their information on a separate sheet of paper. If applying for coverage for a dependent who does not live with you, you must include proof that (s)he lives in Washington State. Dependent children attending school out of state who continue to maintain their residence in Washington are considered Washington State residents.

1. Last name	First name	Middle initial	Social security number – –	Birth date / /	Sex ❑ Male ❑ Female

Applying for coverage for this dependent? ❑ Yes ❑ No	U.S. citizen or lawfully admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival / /	Do you want this child enrolled in Basic Health *Plus*? ❑ Yes ❑ No If yes, include SSN.	Do you want to pay for Basic Health coverage for this child while Basic Health *Plus* eligibility is being determined? ❑ Yes ❑ No (Please note: You may have to wait for space to become available in BH.)	Full-time student (age 19-22)? ❑ Yes ❑ No If yes, send proof from school.	Disabled and over age 19? ❑ Yes ❑ No If yes, receiving Social Security Disability? ❑ Yes ❑ No Entitlement date / /

Receiving medical assistance from DSHS? ❑ Yes ❑ No	Is child living in Washington? ❑ Yes ❑ No	Is child living in your home? ❑ Yes ❑ No If no, list child's address (only if applying for coverage)	Relationship to applicant

2. Last name	First name	Middle initial	Social security number – –	Birth date / /	Sex ❑ Male ❑ Female

Applying for coverage for this dependent? ❑ Yes ❑ No	U.S. citizen or lawfully admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival / /	Do you want this child enrolled in Basic Health *Plus*? ❑ Yes ❑ No If yes, include SSN.	Do you want to pay for Basic Health coverage for this child while Basic Health *Plus* eligibility is being determined? ❑ Yes ❑ No (Please note: You may have to wait for space to become available in BH.)	Full-time student (age 19-22)? ❑ Yes ❑ No If yes, send proof from school.	Disabled and over age 19? ❑ Yes ❑ No If yes, receiving Social Security Disability? ❑ Yes ❑ No Entitlement date / /

Receiving medical assistance from DSHS? ❑ Yes ❑ No	Is child living in Washington? ❑ Yes ❑ No	Is child living in your home? ❑ Yes ❑ No If no, list child's address (only if applying for coverage)	Relationship to applicant

INFORMATION ON OTHER HEALTH COVERAGE Please list any family members who currently have other health insurance (such as Premera Blue Cross, Group Health Cooperative, or an employer-sponsored plan) or are covered under a health program (such as Tri-Care or Medicaid). Be sure to include yourself and/or family members who are not applying for Basic Health coverage, if applicable. Please list subscriber's name for this coverage first. Complete the last three columns below (marked with an *), only if applying for Basic Health *Plus* or the Maternity Benefits Program.

Last name	First name	Middle initial	Health insurance company or health program	Phone number of insurance company or health program*	Policy or group number*	Policy end date*
1. (Subscriber)				( )		/ /
2.				( )		/ /
3.				( )		/ /

SECTION TWO

COMPLETE THIS SECTION IF YOU ARE APPLYING FOR BASIC HEALTH *PLUS* FOR ANYONE ON THIS APPLICATION If the other biological parent of your child(ren) is not legally married to you, but lives in your home, provide the information below. This allows the parent to be counted in the household size and the parent's income to be considered as part of the household income for Basic Health *Plus* eligibility. Provide proof of this parent's income for the most recent 30 days or complete calendar month.

Last name	First name	Middle initial	Birth date / /	Social security number (required) – –

Please list the full name(s) of this parent's child(ren), as listed on this application.	Daytime phone number ( )

SECTION THREE

GROUP COVERAGE Complete this section *only* if your premium is paid-in-full or in-part by your employer, home care agency, or financial sponsor. Return this completed form directly to your employer, home care agency, or financial sponsor.

Employer/organization	Group I.D. number (if known)

Mailing address	City	State	ZIP Code	Phone number ( )

SECTION FOUR

HEALTH PLAN SELECTION You and your family will remain with the health plan that currently provides your Basic Health coverage, unless you are moving to an area not served by your health plan. A list of the health plans available to you, along with their monthly premiums, is in the *How Much Will Basic Health Coverage Cost?* brochure. All plans provide the same basic benefits, but premiums and providers available vary from plan to plan.

I choose to receive Basic Health or Basic Health *Plus* coverage for myself and my family members through the following health plan: _____

(Name of health plan)

PLEASE NOTE: If you change plans any time during the year except during open enrollment, the amount you've paid toward your deductible and out-of-pocket maximum for covered members will start over with your new health plan.

Instructions and Guidelines

If you have questions about the information or documentation needed, call Basic Health at **1-800-660-9840**.

If you need additional copies of this form, you can print them from the Internet at **www.basichealth.hca.wa.gov**, call Basic Health to request them, or photocopy this form.

Adding a new family member: If your application to add a new spouse, child, or dependent is not received within the timeframes below, Basic Health (BH) will count them when calculating your monthly premium based on family size, but will not add them for coverage until the next BH open enrollment period, usually in the fall of each year. To add a new family member to your BH account, all required forms and documentation must be received at BH as follows:

Marriage: Within 30 days of the date of your marriage
Newborn or newly adopted child: Within 60 days of the birth or placement for adoption
Other dependents: Within 30 days of the date they become your dependent or moved into your home

Adding a new family member may change your monthly premium. You will receive written notice of any changes to your account.

If you are applying to add a child age 19 through 22, you will be required to provide proof that they are attending school full time. If you are applying to add a child or disabled adult dependent who is not your biological child, adopted child, or stepchild, you must provide a copy of the court order giving you legal guardianship. You may also be able to add a child to your account under an informal guardianship agreement, but only if the child will be enrolled for coverage. In this case, you must provide a copy of the guardianship agreement signed by the parent(s) of the child, authorizing you to make decisions and obtain medical care for the child, and documentation to show that you are providing at least 50% of the child's support.

Divorce/separation: We must receive all forms and documentation within 30 days of the date you reported the change to Basic Health. If you have reconciled and are living in the same home, you must notify Basic Health in writing, and we will stop the separation of your account.

Transfer of student to separate account: The student must return all required forms and documentation within 20 days of the date on the enclosed letter. If the forms and documentation are not received by the due date, your student may have a break in coverage. See the enclosed *How Much Will Basic Health Coverage Cost?* brochure to estimate your student's monthly premium.

SECTION FIVE

AGREEMENT (must be signed)

I understand that:

- I must report changes in my job or other sources of income (such as a new job or promotion, going from part-time work to full-time work, or a change in child support or other income) within 30 days of the end of the first month at the new income level.
- I must send proof of my gross family income (before taxes) when requested by BH or when reporting a change.
- I must report address changes and changes in my family (for example, a marriage or divorce, the birth of a child, or a child who leaves the home or is no longer a dependent or full-time student) within 30 days of the change.
- BH may check information through contact with other state or federal agencies about my family's income, Washington State residence, eligibility for Medicare, and any other information needed to verify my eligibility for enrollment in BH.
- My signature on this form authorizes BH to use the information provided to verify my family income or eligibility with other agencies or my employer.

I authorize my family's current or former health plan(s) or medical provider(s) to give BH any non-medical records that are necessary for participation in BH, for the persons signing below and for my children under age 18. This authorization will continue for as long as I remain enrolled in BH.

The information I have given in this form and the documents I'm enclosing are true, correct, and complete to the best of my knowledge. I understand that if I withhold information or give BH false or misleading information, my family and I will lose coverage. BH may also bill me for up to two times the amount the state paid for my family's coverage. If I have given false information, BH may prosecute me for perjury or charge me for services received through fraud. If I am billed for past premiums or penalties but do not pay, the state may refer me for collection or bill my estate.

Must be signed by you and your spouse

X _____	_____	X _____	_____
Your signature	Date	Spouse's signature	Date

Signature of all children age 18 and over who receive Basic Health coverage

X _____	_____	X _____	_____
Signature	Date	Signature	Date

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's (the agency that administers Basic Health) Privacy Notice is available upon request by calling 360-923-2822 or online **www.hca.wa.gov**.